STATE GUIDELINES

10-00 - GENERAL GUIDELINES

The intent of state and federal legislation is to assure that the AIDS Drug Assistance Program (ADAP) funds are used only for the purchase of ADAP formulary drugs which cannot be paid for through other sources (Medi-Cal, private insurance, prepaid plans, or other state or local compensation plans). **ADAP is the payer of last resort[1].**

Individuals are eligible for ADAP if they:

1) are HIV infected;

2) have an annual federal adjusted gross income below $50,000;

3) are not fully covered by or eligible for Medi-Cal or other third-party payer;[2]

4) are a resident of California;

5) are 18 years of age or older; **and**

6) have a valid prescription from a California licensed practicing physician.

An individual is subject to a co-payment obligation if his/her annual federal adjusted gross income is between 400 percent of federal poverty level and $50,000. Individuals with a federal adjusted gross income below 400 percent of federal poverty level receive ADAP formulary drugs free of charge. ADAP annually releases a policy Management Memo which identifies the 400 percent federal poverty level and confirms the minimum income level for co-payment obligations.

10-10 - Responsibility for Eligibility Compliance

- The ADAP enrollment worker is responsible for screening all available resources for prescription coverage prior to enrolling a client in ADAP.

- Local health jurisdictions, ADAP coordinators, and ADAP enrollment workers must assure all client eligibility requirements are met, documented, and maintained in a hard copy client file, with client information updated annually upon recertification. (This is also a requirement if the enrollment worker electronically enrolls the client.)

- Enrollment workers/enrollment sites that knowingly enroll clients with inaccurate or false documentation will be removed from ADAP eligibility screening and enrollment responsibilities.

[1]ADAP is the payer of last resort with the exception of certain local programs, i.e., County Medical Services Program, and County Medical Indigent Services.
[2]Please refer to Sections 80-20, Medi-Cal Share of Cost, and 90-00 Private Health Insurance, for further detail.

- It is the client's responsibility to provide accurate and complete information to establish ADAP eligibility and to update ADAP, through the local enrollment worker, of any changes in income, address, telephone number, or third-party payer coverage that would affect their ADAP eligibility. Any client who knowingly provides inaccurate or false information will be suspended from the ADAP program.

- It is the ADAP enrollment worker's responsibility to notify ADAP of any known changes in client income, address, or third-party payer coverage that would affect the client's eligibility.

10-20 - 30-Day Grace Period/Client Update Form

If a client is unable to provide any of the required proof of eligibility documentation, but the enrollment worker is reasonably assured that eligibility can be documented, the enrollment worker is to request a 30-day grace period from the ADAP contracted Pharmacy Benefits Management (PBM) Service Provider by requesting a 30-day grace period on the enrollment application form. Clients issued a 30-day grace period must complete the "30-Day Grace Period Request" form (see Attachment A).

Upon receipt of the required documentation from the client, the enrollment worker is to submit a completed "Client Update" form (see Attachment B) to the PBM, a copy of which is retained in the client's file. Failure to submit this form will result in the client's dis-enrollment at the end of the 30-day grace period. This procedure is to be followed for *any* of the required documentation upon initial application and each recertification with the exception of Medi-Cal application grace periods (see Section 80-20).

10-30 - Identification Requirement

ADAP clients are required to provide photo identification upon application. Acceptable forms of ID include:

- Driver's license;

- United States Passport, Permanent Residence Card, Work Permit, etc. (expired cards may be used if no other form of picture identification is available);

- State identification card;

- School identification card; and

- A photo identification document issued by a foreign government (i.e., voter registration card).

If a client does not have any of the above proof of identity, a non-photo identification document (e.g., birth certificate, verification from a health care provider, etc.) may be used in lieu of the above required documentation. This option may only be used as an absolute last resort.

NOTE: A copy of the required documentation must be maintained in the client's eligibility file.

An enrollment worker who knowingly enrolls a client under a false name will be removed from ADAP eligibility screening/enrollment responsibilities. Persons using aliases cannot legally comply with the eligibility application and documentation requirements established for ADAP and are, therefore, ineligible for the program.

10-40 - Social Security Number (SSN) Requirement

All ADAP clients with a SSN must provide their SSN as part of the ADAP application requirements. This information is necessary to assure ADAP is the payer of last resort. ADAP will use the SSN solely for the purpose of cross-referencing for third-party payer eligibility.

20-00 - INITIAL APPLICATION - PROOF OF HIV STATUS

20-10 - HIV Status Requirement

The federal Department of Health and Human Services, Division of HIV Services, has established policies to guide implementation of Titles I and II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. CARE Act funds are to be used solely for the provision of services to persons infected with HIV and those who have clinically defined AIDS. ADAP must ensure all ADAP clients fall within these service criteria and, therefore, clients must provide documentation of their HIV status as part of the eligibility determination process.

HIV verification is required during the initial application process. HIV verification can be established by **one** of the following:

1) a letter from the client's prescribing physician, with the physician's signature, verifying the client's status: year of positive HIV diagnosis, AIDS status/date of diagnosis, CD4 count, and viral load within the prior six months, and the type viral load test performed (PCR, bDNA, NASBA).

2) physician's completion of the "Diagnosis Information" form (see Attachment C).

If a client is unable to submit the required HIV certification, lab results indicating the client's HIV status, the client's CD4 count, and HIV viral load are acceptable.

NOTE: This documentation must be maintained in the client's eligibility file.

30-00 - ELIGIBILITY RECERTIFICATION REQUIREMENTS

To ensure that ADAP remains the payer of last resort, ADAP clients must have their eligibility recertified annually on their birthday. **Thirty (30) days prior** to the client's **annual eligibility expiration date**, the PBM will send both the client and the enrollment site/local ADAP coordinator notification of the impending eligibility recertification date, thus, giving the client 30 days in which to complete the recertification process. *Under certain circumstances,* the client may also have an additional 30 days after the due date to comply with the recertification process. Failure to complete the recertification process by the specified time frame will result in the client being ineligible for ADAP services. **All eligibility requirements must be recertified through review of updated, current eligibility proof documents provided by the client and retained in the client files.**

30-10 - Current Health Information Required at ADAP Annual Recertification

When recertifying ADAP eligibility annually, viral load and CD4 count dated within the prior six months must be provided. The lab results must be documented in the ADAP application. A copy of the lab report must be maintained in the client's eligibility file.

CD4 count and viral load may be established by one **of the following:**

1) **Physician completion of the "Diagnosis Information" form (see Attachment C).**
2) **A lab report dated within the prior six months.**
3) **A letter from the client's treating physician.**

NOTE: The above documentation must indicate the type of viral load test performed (PCR, bDNA, NASBA).

There is an increasing demand that ADAP demonstrate how public dollars improve health outcomes for HIV-positive clients. Clients usually have viral load and CD4 blood tests on a quarterly basis, and accessing this information should not be difficult in most cases.

If the appropriate lab results are not available, the enrollment worker must request a 30-day grace period on the enrollment application form and the client must complete the "30-Day Grace Period Request" form (see Section 10-20). Completion of this form indicates that the client is "self-certifying" his/her intent to provide the information within the 30-day grace period. If appropriate lab results are not provided at the end of the 30-day grace period, the client is **ineligible for ADAP until the required proof is submitted.** Upon receipt of the required documentation from the client, the enrollment worker is to submit a completed "Client Update" form (see Section 10-20) to the PBM, a copy of which is retained in the client's file. Failure to submit this form will result in the client's dis-enrollment at the end of the 30-day grace period.

40-00 - RESIDENCY REQUIREMENT

ADAP clients **must** live in California and this residency **must** be documented. Documentation shall include a rent receipt, copy of lease, utility bill, voter registration card, vehicle registration, property tax statement, current W-2 or 1099 or other document in the client's name that verifies current California residency.

Persons who do not have the above documentation **(i.e., living with or supported by family/partner)** may prove residency by providing the "**Support Verification Affidavit"** (see Attachment D). The Support Verification Affidavit should be completed by the person who is providing support (e.g., food, shelter, clothing) to the client. If the client is homeless, the client will have this form completed by their AIDS case manager, AIDS service provider, or social service provider, providing the location and time period services have been/continue to be provided to the client. A letter on letterhead from the client's case manager or service provider providing the location and time period services have been/continue to be provided to the client will also be considered acceptable documentation. If no other residency documentation is available, the client may provide a recent paycheck stub issued within the last six months, in their name, by a local employer.

A California driver's license alone is not proof of residency.

A P.O. Box is not acceptable as proof of residency.

NOTE: **A copy of the documentation used to establish California residency must be placed in the client's file.**

NOTE: The California residency requirement is not related to immigration status.

50-00 - MINORS

Children (persons under 18 years of age) are generally not eligible for ADAP. Minors must be referred to: (1) Medi-Cal; (2) Department of Health Services, California Children Services (CCS) for eligibility determination under the HIV Children's Program; or (3) any other third-party payer.

If a minor is determined to be ineligible under all of these options, and documentation to that effect is provided, exceptions may be considered on a case-by-case basis. In such a case, the eligibility worker should contact the PBM who will then submit an Exception Request to the Office of AIDS (OA). OA approval must be obtained prior to enrolling any minor (see Section 130 -10).

60-00 - PRESCRIPTIONS FROM CALIFORNIA LICENSED PHYSICIANS

Only prescriptions from California licensed physicians **practicing in the state** will be filled by pharmacies on the ADAP dispensing network. Out-of-state physician prescriptions will not be accepted.

70-00 - FINANCIAL ELIGIBILITY DETERMINATION

70-10 - Income Eligibility Determination

Federal Adjusted Gross Income (FAGI) Establishes Eligibility

Individuals who have a FAGI that does not exceed $50,000 are eligible for ADAP.

For the purpose of thorough income screening, ADAP requires that clients disclose all income sources, both taxable and nontaxable. **However, the client's FAGI, as defined by the Internal Revenue Service, will be used to establish financial eligibility for ADAP.**

Examples of client income include:

- State Disability Insurance (SDI).
- Social Security Disability Insurance (SSDI).
- Social Security Retirement.
- Employment Income.
- Spousal Support.
- General Relief/General Assistance.
- Private Disability.
- Unemployment Insurance (UI).
- Retirement/Pension.
- Worker's Compensation.
- Investment Income.
- Veteran's Administration Benefits (VA).

Clients are required to provide current documentation to prove financial eligibility for ADAP. All clients are strongly encouraged to submit their current tax return to establish eligibility, as this document tends to provide the most accurate information regarding a client's FAGI. Clients who are unable to provide a current tax return may provide alternative income documentation.

Examples of acceptable income documentation include:

- Individual California State Tax Return with corresponding W-2 or 1099.
- Individual Federal Income Tax Return with corresponding W-2 or 1099.
- Disability Award Letter.
- Paycheck stubs for the prior three consecutive months, indicating the pay period (i.e., weekly, bi-monthly, monthly, etc.).
- Bank Statement. Statement must clearly indicate income source (SSDI, Social Security Retirement, VA).
- Cash Assistance Program Receipt (General Assistance).

All sources of income are to be identified and totaled using the "**Financial Screening and Co-Payment Determination" form (see Attachment E). A copy of the document(s) used to establish ADAP financial eligibility must be maintained in the client's file.**

NOTE: PERSONS WHOSE FAGI EXCEEDS $50,000 ARE INELIGIBLE FOR ADAP.
Health and Safety Code Section 150960 (b):

Allows the Director of the Department of Health Services narrowly defined discretion regarding the provision of services to persons whose income exceeds $50,000. At this time, no exceptions will be made. Any change in this policy will be communicated via an ADAP Management Memo.

If the required income documentation is not available at the time of enrollment or recertification, the enrollment worker must request a 30-day grace period on the enrollment application form and the client must complete the "30-Day Grace Period Request" form (see Section 10-20) in order for the client to be granted "interim eligibility" for ADAP services. If the client does not provide the necessary financial documentation by the end of the 30-day grace period, **the client is ineligible for ADAP until such proof is provided.**

If a client claims to have **no source of income**, the client must "self-certify" to that effect by completing the "Support Verification Affidavit" (see Attachment D). Both the client and the person or agency providing support to the client must complete the affidavit. If the "Support Verification Affidavit" is not completed at the time of the initial application, a 30-day grace period (see Section 10-20) may be granted. If the affidavit is not submitted by the end of the 30-day period, **the client is ineligible for ADAP until such proof is provided.**

70-20 - ADAP Co-Payment Obligation Determination

The ADAP "Financial Screening and Co-Payment Determination" form (see Attachment E) will be used to calculate the appropriate co-payment. Copies of all substantiating documentation must be attached to the form and placed in the client's file. If it is determined that a client has a co-payment, the enrollment worker will submit the co-payment calculation to the PBM for confirmation.

70-30 - Co-Payment Appeals

Health and Safety Code Section 150960 (d):

Persons who have been determined to have a payment obligation pursuant to subdivision (c) shall be advised by the department of their right to request a

reconsideration of that determination to the department. Written notice of the right to request a reconsideration shall be provided to the person at the time that notification is given that he or she is subject to a payment obligation. The payment determination shall be reconsidered if one or more of the following apply:

(1) The determination was based on an incorrect calculation made pursuant to subdivision (b).

(2) There has been a substantial change in income since the previous eligibility determination that has resulted in a current income that is inadequate to meet the calculated payment obligation.

(3) Unavoidable family or medical expenses that reduce the disposable income and that result in current income that is inadequate to meet the payment obligation.

(4) Any other situation that imposes undue financial hardship on the person and would restrict his or her ability to meet the payment obligation.

Health and Safety Code Section 150960 (f):

If a person requests reconsideration of the payment obligation determination, the person shall not be obligated to make any payment until the department has completed the reconsideration request pursuant to subdivision (d). If the department denies the exemption, the person shall be obligated to make payments for drugs received while the reconsideration request is pending.

Co-payment appeal determination shall be considered on a case-by-case basis. Clients must submit their appeal through the local ADAP coordinator using the "ADAP Financial Hardship Co-Payment Appeal" form (see Attachment F). The ADAP coordinator will forward the completed form to the PBM who will then forward the appeal to OA for determination.

70-40 - ADAP Clients Enrolled Prior to March 15, 1991

Health and Safety Code Section 150965 (b), (c) and (d):

(b) Persons who are receiving benefits under a HIV drug treatment subsidy program administered by the department prior to March 15, 1991, shall not be subject to the payment obligation specified in subdivision (c) of Section 150960.

(c) Notwithstanding subdivision (b), if any person is dis-enrolled from eligibility in a HIV drug treatment subsidy program administered by the department for any reason after March 15, 1991, the subsequent enrollment of that person for

benefits under this chapter shall be in accordance with the payment obligation specified in subdivision (c) of Section 150960.

(d) Notwithstanding subdivision (b), if a drug is added pursuant to subdivision (a) of Section 150955, any person determined eligible for benefits under this chapter, regardless of the date of enrollment, shall be subject to the payment obligation specified in subdivision (c) of Section 150960 for the added drug. The payment obligation for any other drug shall be determined in accordance with subdivision (b).

Persons who maintain the free AZT and pentamidine benefit are subject to the current financial eligibility criteria applicable for all of their other ADAP drugs.

80-00 - MEDI-CAL

Health and Safety Code Section 150950 (c):

Persons who are eligible for and/or receive 100 percent coverage under Medi-Cal are ineligible for ADAP. ***Medi-Cal's drug formulary includes all drugs on the ADAP formulary.***

80-10 - Medi-Cal Eligibility Assessment

All clients must be screened for current or potential Medi-Cal eligibility as part of the ADAP eligibility determination process. Clients who are enrolled in Medi-Cal and have no share-of-cost obligation are not eligible for ADAP.

Medi-Cal eligibility must be thoroughly assessed and documented in the client file at the time of initial enrollment and annual recertification. Any ADAP applicant who may qualify for Medi-Cal must be referred to Medi-Cal for application. This includes individuals with Medicare and/or private insurance coverage.

Reasons for not referring a client to Medi-Cal are limited to the following:

- Client's assets exceed Medi-Cal's limits.
- Client does not meet Medi-Cal's immigration requirements.
- Client is currently employed and is not disabled.
- Client is receiving Unemployment Insurance.
- Client has been denied Medi-Cal, Supplemental Security Income (SSI), or Social Security Disability Insurance (SSDI) within the past 12 months.

A denial based on the clients' failure to comply with the application process will not be considered an acceptable denial for ADAP purposes.

In an effort to ensure that ADAP is the payer of last resort, all clients who do not meet one of the above criteria, are required to apply for Medi-Cal. Clients who are not referred to Medi-Cal must provide documentation supporting that they are ineligible for Medi-Cal. **A copy of the documentation must be maintained in the client's file.**

Acceptable documentation to prove Medi-Cal ineligibility includes:

- Bank statements, property deeds, or vehicle registration that demonstrates assets above Medi-Cal limits.
- Employment paycheck stubs.
- Unemployment Insurance award letter or payment stub.
- Medi-Cal, SSI, or SSDI denial letter dated within the past 12 months.

ADAP recognizes that in some cases Medi-Cal ineligibility related to immigration status may be difficult to document. Therefore, clients are not required to provide documentation to prove Medi-Cal ineligibility related to immigration.

Enrollment workers should indicate that the client was not referred to Medi-Cal by documenting "Ineligible Immigrant" on the ADAP application. Please note that ADAP does not require that you disclose the client's formal immigration status (undocumented, Visitor Visa, Work Permit, etc.).

Please see the Ramsell Training Manual for additional detailed information regarding Medi-Cal eligibility.

80-20 - Medi-Cal Application Timeline Requirements

Initial Medi-Cal Applications:

A client who is potentially eligible for Medi-Cal must apply within 30 days of ADAP application or recertification. The client is required to provide ADAP with proof that they have applied for Medi-Cal. **A copy of the "pending Medi-Cal application" documentation must be maintained in the client's file.**

At the time of ADAP application or recertification, the client must "self-certify" their intent to submit a Medi-Cal application by completing a "30-Day Grace Period Request" form (see Section 10-20) in order to be enrolled in ADAP. The client is then granted interim eligibility for ADAP services pending submission of the Medi-Cal application.

If no proof of Medi-Cal application is submitted to the enrollment worker by the end of the 30-day period, the client's ADAP **eligibility will be suspended until such proof is submitted.**

Pending Medi-Cal Applications:

Once the PBM receives the "Client Update" form indicating that the client has applied for Medi-Cal, the PBM will grant the client an additional 150-day interim eligibility period for ADAP services pending outcome of the Medi-Cal eligibility determination.

Near the end of the 150 day interim eligibility period, the PBM will fax the enrollment worker notification if the client has not yet provided proof to the enrollment worker of the Medi-Cal eligibility determination. Enrollment workers are encouraged to contact their clients to determine the status of the client's Medi-Cal applications. Enrollment workers who are having difficulty determining the status of their client's Medi-Cal applications should contact the PBM for assistance. Assuming that the client has provided all required information to Medi-Cal, the PBM may grant ADAP eligibility extensions to clients who have Medi-Cal applications pending beyond the 150 day period. Extensions will be granted only when there are documented, extenuating circumstances. Failure to comply with the Medi-Cal application process in a timely manner will not justify an ADAP extension beyond the 150 day grace period.

If it is determined that the client did not comply with the Medi-Cal application process (e.g., submitted initial application but did respond to requests for additional supporting documentation), the PBM will notify the enrollment worker and the client will be required to reapply for Medi-Cal. The client will be granted a new 30-day Medi-Cal application/90-day Medi-Cal eligibility determination interim ADAP eligibility period.

Clients who fail to comply with the second Medi-Cal application process will be suspended from ADAP.

Medi-Cal Determinations:

Medi-Cal will mail the client a "Notice of Action" once they have made a determination regarding the client's eligibility. The client is required to provide the enrollment worker with the Medi-Cal determination documentation. **A copy of the documentation must be maintained in the client's file.** The enrollment worker then faxes the "Client Update" form to the PBM advising the PBM of the client's Medi-Cal status.

Clients who are denied Medi-Cal will be granted full ADAP eligibility. **The client must be rescreened at each annual ADAP recertification to assess potential Medi-Cal eligibility.**

A denial based on the clients' failure to comply with the application process will not be considered an acceptable denial for ADAP purposes.

80-30 - Medi-Cal Share of Cost (SOC)

Clients who are enrolled in Medi-Cal with zero SOC will be terminated from ADAP. These individuals are entitled to drug coverage under Medi-Cal.

Clients who are enrolled in Medi-Cal with a SOC may be eligible for ADAP if the SOC payment represents a financial hardship to the client. ADAP will pay for drugs on the ADAP formulary up to the client's Medi-Cal SOC amount.

NOTE: It is recommended that ADAP/Medi-Cal SOC clients have their ADAP drugs (up to the SOC amount) **dispensed at the beginning of the month.** This allows the ADAP/Medi-Cal SOC client to access other Medi-Cal covered services for the remainder of the month without incurring additional SOC expenses.

80-40 - Medi-Cal SOC with Private Insurance/Prescription Benefit

Per Medi-Cal policy, if a person has private insurance, the private insurance is considered the primary policy, and Medi-Cal is considered secondary. If an ADAP client has Medi-Cal with a SOC and private insurance with a prescription benefit, ADAP shall only be used to meet the Medi-Cal SOC and prescription costs not covered by private insurance.

90-00 - PRIVATE HEALTH INSURANCE

All ADAP applicants must be screened for existing private health insurance coverage. Such coverage does not automatically disqualify an individual from ADAP eligibility. However, ADAP is to be billed only after available health insurance coverage is exhausted.

A copy of the client's insurance benefit document (i.e., health insurance card with explanation of benefit) must be placed in the client's file.

NOTE: Clients who withhold private insurance/prescription benefit information and enroll in ADAP will be removed from ADAP until such time as a determination is made regarding ADAP eligibility. Such clients may be held liable for prescription costs incurred by ADAP that were otherwise billable to the private insurance.

90-10 - Private Health Insurance with a Prescription Benefit Cap

Any available benefit must be exhausted in order for a client to be eligible for ADAP services. When clients have exhausted their private insurance prescription benefit, they are eligible for ADAP services if they meet all ADAP eligibility requirements and are enrolled. If a client has a limited annual prescription benefit (e.g., $1,000 annual cap), this benefit cannot be reserved for non-ADAP drugs. The client would be able to use ADAP only until their private insurance prescription benefit was renewed (i.e., for a monthly cap, when a new month begins, or for an annual cap, when a new calendar year begins).

90-20 - Private Health Insurance that Covers a Percentage of Prescription Costs

A client with private insurance that covers a percentage of prescription costs, (i.e., 85 percent of the drug cost), may be eligible for ADAP. The ADAP benefit to the client will be limited to the portion of the drug cost not paid for by the private insurance for ADAP formulary drugs.

90-30 - Private Health Insurance that Covers a Portion of Drug Costs and Requires the Use of "Preferred Pharmacies"

If a client has private insurance with a prescription benefit that requires the use of specified pharmacies for reimbursement benefit ("preferred pharmacies"), and those preferred pharmacies **are not** part of the ADAP dispensing network of pharmacies, the client is ineligible for ADAP.

ADAP may grant exceptions on a case-by-case basis. If, however, the client has a prescription for a drug that is not on their private insurance formulary, and the client meets all ADAP eligibility requirements and is enrolled, ADAP can be accessed for ADAP formulary drugs that are not covered by the private insurance formulary.

90-40 - Private Insurance with a Per Prescription Co-Pay Requirement

ADAP can be accessed to pay an individual's private insurance prescription co-payment requirement **if** the individual meets all ADAP eligibility requirements, is enrolled, and it is determined by the enrollment worker/ADAP coordinator that the client has no other means to pay this obligation.

90-50 - Private Health Insurance with Other Prescription Benefit Requirements/Limits

For other types of insurance benefits not described here, contact OA, ADAP for guidance on available program benefits.

100-00 - OTHER THIRD PARTY PAYERS

100-10 - Insurance Continuation and Premium Payment Programs

All ADAP applicants must be assessed for any existing or recently expired insurance coverage that could be acquired or continued through an insurance continuation program. Continuing health insurance coverage is preferable for most clients since they receive medical as well as prescription benefits.

Insurance continuation options include:

Consolidated Omnibus Budget Reconciliation Act (COBRA)
Omnibus Budget Reconciliation Act (OBRA)
California Major Risk Medical Insurance Plan (MRMIP)
Health Insurance Portability and Accountability Act (HIPAA)

Clients who are eligible to continue insurance but are in need of premium payment assistance should be referred to the Comprehensive AIDS Resources Emergency/Health Insurance Premium Payment (CARE/HIPP) Program or Medi-Cal HIPP Program. ADAP may then be used in accordance with the private insurance benefit, (see Section 90-00 ”Private Health Insurance”).

Please see the Ramsell Training Manual for further information regarding CARE/HIPP and Medi-Cal HIPP.

100-20 - County Medical Services Program (CMSP)

CMSP beneficiaries who are HIV infected are **eligible** to receive prescription services through ADAP. These services include access to all ADAP formulary drugs. *CMSP beneficiaries must enroll in ADAP to receive ADAP benefits.*

NOTE: CMSP does not recognize ADAP paying for drugs as meeting the client’s CMSP SOC. Instead, it is viewed as increased income for the client. Therefore, ADAP cannot be used to meet a CMSP client’s SOC.

100-30 - VA Benefits

Clients must be assessed for any VA eligibility as part of the ADAP eligibility determination process. Any ADAP applicant who might qualify for VA must be referred to the VA for application. **Persons who are eligible for medical and 100 percent prescription benefits under the VA program should access VA clinics/hospitals for their drugs.** Exceptions will be made if accessing the VA healthcare system presents a hardship for an otherwise ADAP eligible client.

Persons who are eligible for medical and limited prescription benefits under the VA program are eligible for ADAP only for prescription benefits not covered by the VA. They must meet all ADAP criteria, be enrolled in ADAP, and the drugs must be on the ADAP formulary.

100-40 - "Medicare Advantage:" Medicare Health Maintenance Organization Coverage with Prescription Benefit

Persons who have Medicare HMO insurance coverage that includes prescription benefits must use their prescription benefit before accessing ADAP. The prescription benefit provided by the HMO will determine the client's potential ADAP benefit (see Section 90-00, "Private Health Insurance" for clarification on ADAP benefits).

100-50 - Medicare Prescription Drug Discount Cards

Effective June 1, 2004, Medicare began offering a prescription drug discount card program. Persons with income below 135 percent of the Federal Poverty Level may be eligible for a $600 drug credit as part of their Medicare drug discount card. The discount card program will act as an interim program, which will end January 1, 2006, when Medicare begins offering drug coverage under "Medicare Part D."

ADAP clients who have qualified for a Medicare discount drug card and $600 credit will be allowed to use the discounts and credit as they wish. The $600 credit may be applied toward ADAP and/or non-ADAP formulary drugs. If the ADAP client chooses to use the $600 credit toward his/her ADAP covered drugs, the client should advise the pharmacy to first bill the Medicare discount card and then bill ADAP.

ADAP policy may change in the future as directed by Health Resources and Services Administration and/or based on our experience. Also, additional policy information will be forthcoming as new Medicare drug benefits take effect on January 1, 2006.

120-00 - NURSING HOMES/INPATIENT CARE

A client who is a patient in a nursing home or hospital is ineligible for ADAP. ADAP cannot pay for services that would otherwise be paid from another source. If the client is in a nursing home or hospital and has no source of payment, he/she is most likely eligible for Medi-Cal. Medi-Cal pays for the cost of all care including medications, for nursing home or hospital patients. Once discharged, the client could apply for ADAP. **ADAP covers only outpatient prescriptions.**

130-00 - EXCEPTION REQUESTS

130-10 - Temporary Eligibility

In certain instances, there may be a need to grant limited-term eligibility to a client who otherwise would not qualify for permanent ADAP coverage. ADAP may grant "Temporary Eligibility" in some instances.

Example: An HIV-positive minor whose aunt did not yet have legal custody of her, and, as a result, could not apply for Medi-Cal for the minor until the aunt was named the child's legal guardian. Because the child was in immediate need of medication, the ADAP eligibility worker and the PBM completed an "Exception Request" and forwarded it to OA for consideration. "Thirty-day Temporary Eligibility" was granted to the child and was reevaluated monthly, thereafter, until the legal matter was resolved and the minor became eligible for Medi-Cal.

Example: A client was enrolled in Medi-Cal Managed Care in Los Angeles. He moved to San Francisco and tried to fill his prescriptions at a San Francisco pharmacy. The pharmacist informed him that he was not covered in San Francisco. Because the client was out of his HIV medication, the ADAP eligibility worker and Ramsell Corporation submitted an "Exception Request" to OA for consideration. The client was granted "Temporary Eligibility" which gave him time to transfer his Medi-Cal eligibility to San Francisco.

If you encounter a client with an unusual situation, contact the PBM who will then follow up with an "Exception Request" to OA, if applicable.

140-00 - RECORD RETENTION AND DISPOSAL

ADAP client files must be retained for a period of four years, (current year plus three prior years).

ADAP client files must be stored in a locked filing cabinet or in a secured (locked) office. **Any ADAP correspondence (to include facsimiles) which includes confidential client information must be filed with the client's application and supporting documents.**

When disposing of ADAP client files, confidentiality procedures must be followed to ensure that identifying information cannot be obtained, (i.e., shredding the files).

150-00 - ENROLLMENT SITE/ ENROLLMENT WORKER TERMINATION

If an ADAP enrollment site ceases to conduct ADAP enrollment, it is the responsibility of the local ADAP coordinator to immediately notify OA/ADAP, the PBM, and to obtain and secure the ADAP client files. Active ADAP clients should be referred to a nearby ADAP enrollment site for assistance in recertifying their eligibility.

If an ADAP enrollment worker ceases to conduct enrollment at an ADAP enrollment site Ramsell Corporation is to be notified within 24 hours, so that their enrollment worker number can be deactivated. To protect client confidentiality, only the individual originally given an ADAP enrollment worker number may use that number.